TENNESSEE DEPARTMENT SAFETY AND HOMELAND SECURITY
Driver Improvement Section
P.O. Box 25290
Nashville, TN 37202

MEDICAL FORM

This report must be completed by a licensed physician, physician assistant, or nurse practitioner in addition to any hospital, medical, or VA records that you wish to make part of your medical history with the Department. This examination must have been performed within the last twelve (12) months.

DRIVER INFORMATION	
Name Last First Middle Initial	Date of Birth
Address Street City State Zip	Driver License Number
Mailing Address (if different from above)	Phone Number
Describe in detail any medical condition(s) you may have.	

Do you take any prescription / non –prescription drugs? YES____ NO____ If yes, list below (attach separate sheet if needed)

Non –Prescription	Dosage	Times taken		Prescription	Dosage	Times taken

Information Release Approval

I hereby authorize a licensed medical provider, _____, to give me any examination he/she deems necessary for the purpose of determining my physical and/or mental fitness to operate a motor vehicle. I also authorize the Department of Safety and Homeland Security to have this information reviewed by a consulting board of unidentified physicians for the purpose of giving the Department a medical evaluation on my case. I understand that the Department is in no way responsible for any expense that arises from this examination.

Signature	Date

VISUAL

Without Glasses	RE 20/	LE 20/	BE 20/
With glasses	RE 20/	LE 20/	BE 20/

Field of vision	Color vision

NEUROLOGICAL / MUSCULOSKELETAL

How long have you treated this Patient? Years _____ Months_____	Have you examined patient in the last six months? Yes_____ No_____ Last Examination date:_____

Diagnosis(es):

Are there any complications related to the condition(s)? Yes_____ No_____ If yes, explain.

Has the patient been hospitalized for the above condition(s) within the past year? Yes_____ No_____
If yes, list dates and status upon discharge.

Does the patient have a history of seizures? Yes_____ No_____ If yes, provide dates of each episode and reason(s).

Indicate the risk of further episodes.

Is the current medication and/or blood serum level within acceptable range? Yes_____ No_____ Date tested:_____	Blood test results:

Does the patient have any motor deficits / nerve problems that would impair his/her driving ability?
Yes_____ No_____ If yes, describe the condition(s) and the effect on their driving.

Does the patient have any other neurological condition(s) that would impair his/her driving ability?
Yes_____ No_____ If yes, describe the condition(s) and the effect on his/her driving.

Does the patient have any chronic condition(s), chronic pain syndrome, fibromyalgia or any other movement disorder? Yes_____ No_____ If yes, specify.

Is the patient prescribed any medication for chronic or long lasting pain? YES____ NO____ If yes, list below.

Prescription	Dosage	Times taken

Does the patient suffer from peripheral neuropathy? YES____ NO____ If yes, which extremities are impaired?		
Current blood levels of anticonvulsant medication:	Test date:	Result of most recent EEG:
Does the neuropathy affect the patient's ability to safely operate a motor vehicle? YES____ NO____		
Does the patient suffer from muscle spasms? YES____ NO____		
Does the patient have full Range of Motion of the head and neck? YES____ NO____ If no, describe the patient's Range of Motion.		

DIABETES

Is this patient a diabetic? YES____ NO____ If no, continue to next section.
Diagnosis:_____ current treatment:_____
Does this patient take insulin? YES____ NO____ If yes, type/dosage:_____
Are there any complications related to this condition? YES____ NO____ If yes, explain.
Has the patient been hospitalized for the above condition within the past year? YES____ NO____ If yes, list dates and status upon discharge.
Does the patient's diabetes or any other metabolic conditions affect their ability to operate a motor vehicle safely? YES____ NO____ If yes, explain.
Do any complications or associated conditions exist? YES____ NO____ If yes, explain.
Does this patient have hypoglycemic reactions? YES____ NO____ If yes, provide dates and reasons.
Does the patient monitor his/her blood sugar? YES____ NO____ If yes, how often?

CARDIOVASCULAR

Does this patient have any type of cardiovascular condition? YES____ NO____ If no, continue to next section.
Diagnosis: _____ Current treatment:_____

Are there any complications related to this condition? YES____ NO____ If yes, explain.
Within the past year, has the patient been hospitalized for the above condition? YES____ NO____ If yes list, dates and status upon discharge.
Does the patient have an implantable cardioverter defibrillator? YES____ NO____ If yes, give date(s).
Has the unit discharged since the implant? YES____ NO____ If yes, explain.
Does the patient have a ventricular assist devise system? YES____ NO____ If yes, when was the devise implanted.

Has the patient had any of the following:
Cardiovascular surgery and/or other procedures? YES____ NO____ If yes, explain and give dates.
Syncope? YES____ NO____ If yes, explain and give dates.
Fatigue with exertion? YES____ NO____ Fatigue at rest? YES____ NO____
Dyspnea with exertion? YES____ NO____ If yes, explain and give dates.
Dyspnea at rest? YES____ NO____ If yes, explain and give dates.
Pulmonary symptoms? YES____ NO____ If yes, explain and give dates.

PULMONARY
Does this patient have any type of pulmonary condition? YES____ NO____ If no, continue to next section
Diagnosis:_____ current treatment:_____
Are there any complications related to this condition? YES____ NO____ If yes, explain.
Within the past year, has the patient been hospitalized for the above conditions? YES____ NO____ If yes, list dates and status upon discharge.
Is oxygen use required? YES____ NO____ If Yes, describe treatment regimen and provide number of liters.
Dyspnea with exertion? YES____ NO____ If yes, explain and give dates.

Dyspnea at rest? YES____ NO____ If yes, explain and give dates.
Syncope from cough? YES____ NO____ If yes, explain cause and resolution.
Does the patient have a diagnosis of sleep apnea? YES____ NO____ If Yes, describe treatment regimen.
Does the pulmonary disease prevent activities of daily living? YES____ NO____ If yes, identify.
Has the patient been compliant with treatment to the extent that the symptoms are controlled? YES____ NO____
Does the pulmonary disease affect the patient's ability to safely operate a motor vehicle? YES____ NO____

PSYCHIATRIC / SUBSTANCE ABUSE

Does this patient have any type of psychiatric and/or substance abuse conditions? YES____ NO____ If no, continue to next section.

Diagnosis:_____ Current treatment:_____

Are there any complications related to this condition? YES____ NO____ If yes, explain.

Within the past year, has the patient been hospitalized for a mental or emotional condition? YES____ NO____
If yes, list dates and status upon discharge.

Was the hospitalization voluntary? YES____ NO____

Does the patient have a condition which results in one or more of the impairments listed below? YES___ NO___
If Yes, check all that apply.

	Poor decision making/ problem solving skills		Memory loss, Cognitive
	Dementia/confusion		Hallucinations/delusions
	Poor impulse control/extremely impulsive		Emotional or behavioral instability
	Extremely aggressive/destructive behavior		Poor/impaired judgment

Identify current treatment programs, counseling, and/or medications, etc...

Is patient currently or has patient successfully completed drug/alcohol program? YES____ NO____
If yes, explain and give dates.

Did the patient experience seizures related to withdrawal? YES____ NO____ If yes, explain and give dates.

Has the patient been compliant with substance abuse treatment? YES____ NO____

GENERAL RECOMMENDATIONS

This section must be filled out and signed by a licensed physician, physician assistant, or nurse practitioner.

Is the patient's condition(s) stable? YES____ NO____ If NO, explain.

Is the patient compliant with treatment? YES____ NO____ If NO, explain.

Does the patient experience side effects of medication, which are likely to impair his/her driving ability?
YES____ NO____ If Yes, explain.

In your medical opinion, is the patient medically safe to operate a non-commercial vehicle?

YES_____ NO_____ AND/OR

In your medical opinion, is the patient medically safe to operate a commercial vehicle such as a tractor trailer, hazardous materials, passenger bus, school bus, etc.?

YES_____ NO_____

In your medical opinion, does the patient need the following: (check all that apply)

	To be retested by the Department on		Knowledge		Road		Both
	A driver evaluation with a certified independent driver evaluation specialist "CDRS"						
	An adaptive device/equipment required on vehicle						
	A prosthetic / orthotic devise		Daylight hours only				

Additional recommended restrictions:

Current medications (attach separate sheet if needed)

Name	**Dosage**	**Time**		**Name**	**Dosage**	**Time**

Physician/ physician assistant/ nurse practitioner (print)	Medical Specialty

Medical license number	Expiration date	Issuing State	Telephone number

Physician/ physician assistant/ nurse practitioner signature	Date